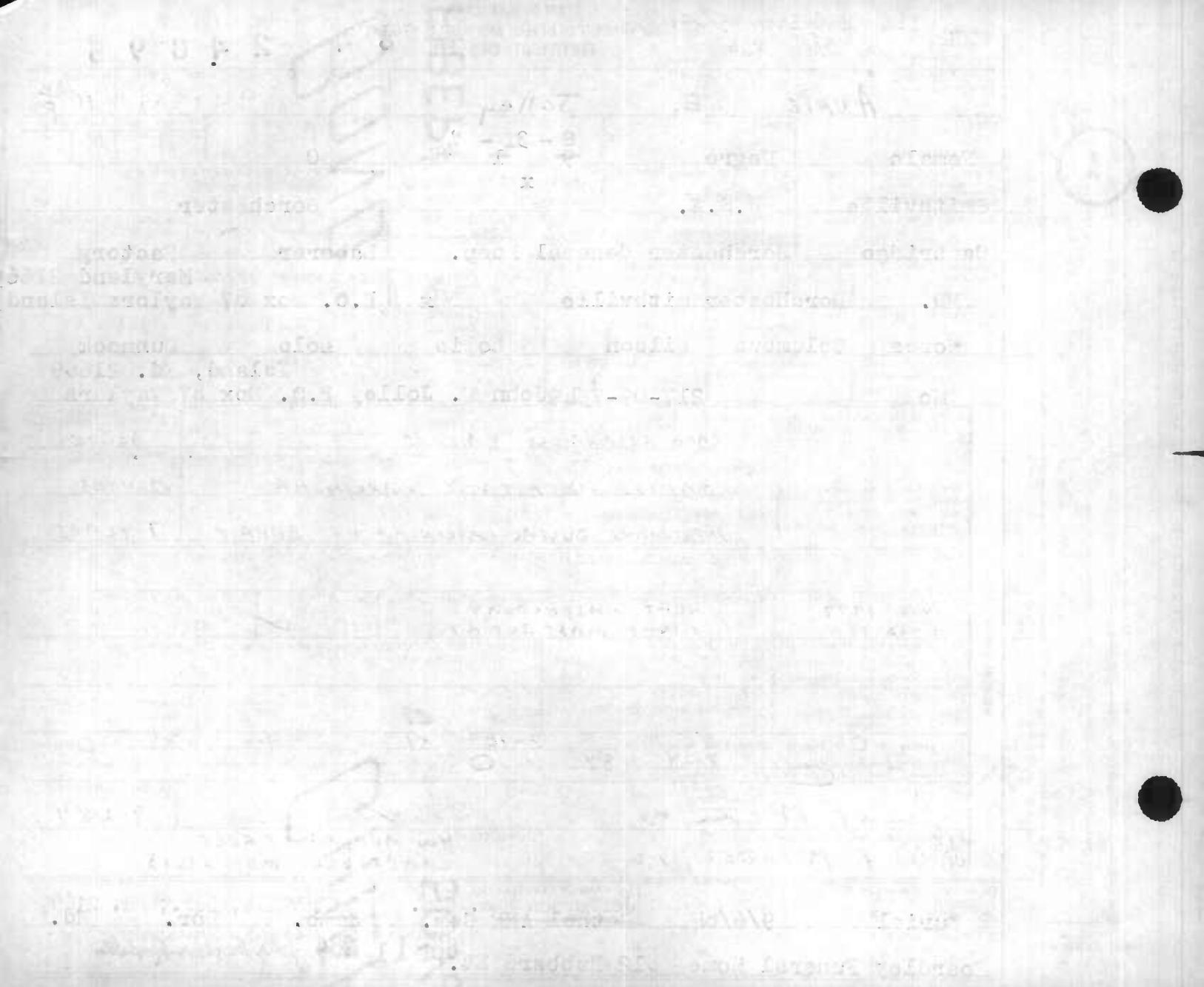


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR 10/25/84 rja			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO. 24895
1. DECEASED NAME (TYPE OR PRINT) <b>ANNIE E. Jolley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-1-84</b>			2b. HOUR <b>10 30</b>
3. SEX <b>Female</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>1900 21 DAY 04 YEAR</b>
6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>			7. IF UNDER 1 YEAR MONTHS <b>80</b> DAYS			8. IF UNDER 24 HRS. HOURS <b>80</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Smithville</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>
13a. STATE <b>MD.</b>			13b. COUNTY <b>Dorchester</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>
13c. CITY OR TOWN <b>Smithville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>Maryland 21669</b>
14. FATHER'S NAME FIRST <b>Moses</b>			MIDDLE <b>Columbus</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Lelia</b>
LAST <b>Wilson</b>			LAST <b>Lola</b>			MIDDLE <b>Dunnock</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-09-7549</b>			17. INFORMANT <b>John W. Jolley P.O. Box 87 Taylors</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost.			DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE METASTATIC CARCINOMA</b>			MONTHS
			DUE TO, OR AS A CONSEQUENCE OF (c) <b>INFILTRATING DUCTAL CARCINOMA OF BREAST</b>			7 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION <b>JUNE 1977 5-28-84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LEFT MASTECTOMY RIGHT MASTECTOMY</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>3-10 1981</b> to <b>9-1 1987</b> , that <input type="checkbox"/> (we) lost saw the deceased alive on <b>8-29 1984</b> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> we <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.						
22b. SIGNATURE <b>James F. McCarter, M.D.</b>		DEGREE			22c. DATE SIGNED <b>9-2-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES F. McCARTER, M.D.</b>		22e. ADDRESS <b>400 AURORA STREET CAMBRIDGE, MD. 21613</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/6/84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Jefferson Mem. Cem. Bethel AMP Cem.</b>		23d. LOCATION <b>Smithville, Dor., Md. 21669</b>
24. FUNERAL DIRECTOR NAME <b>Boardley Funeral Home</b>		ADDRESS <b>812 Hubbard St.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson - Pendleton</b>

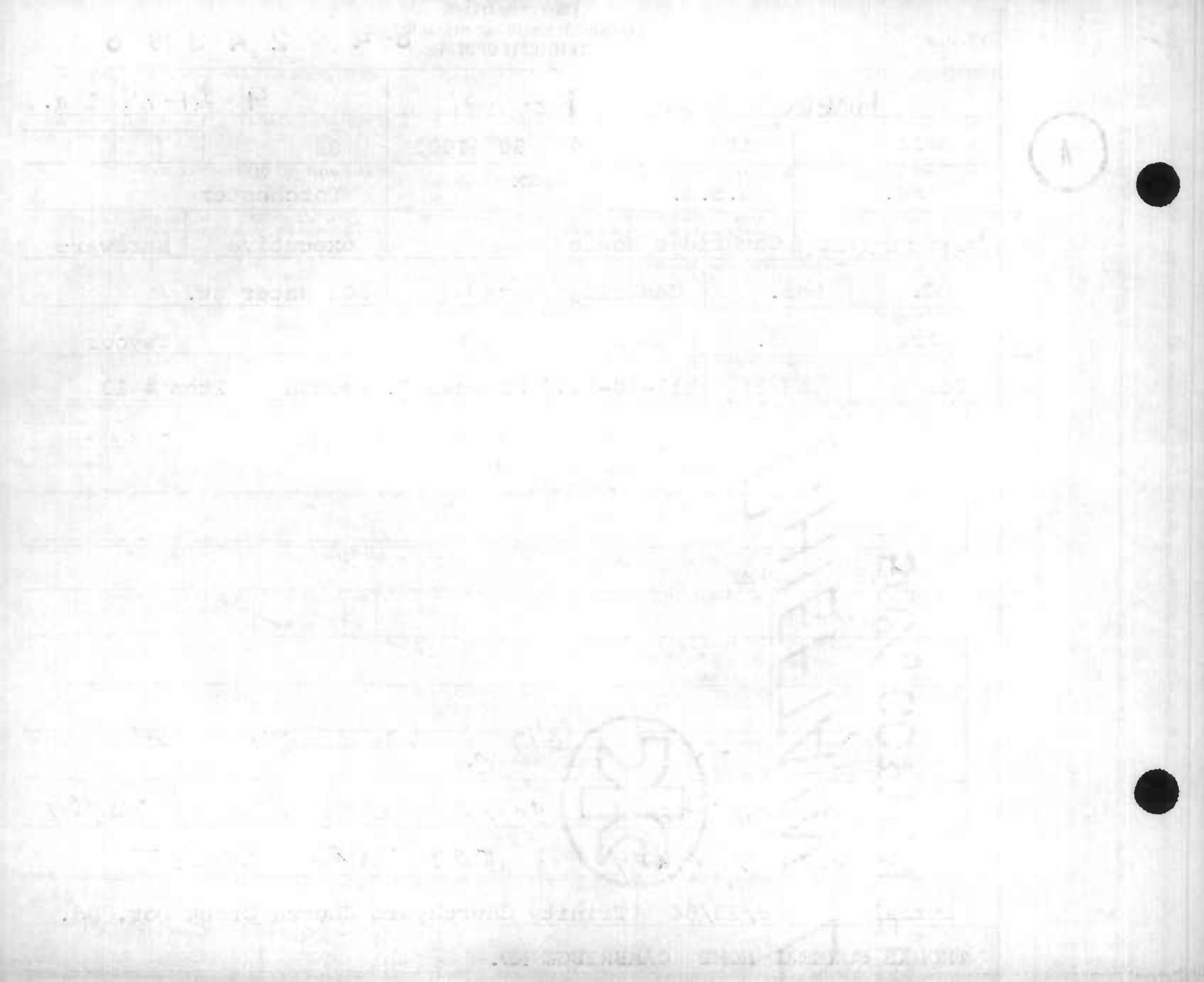


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												24896			
											REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			HARRY E. A. KEENAN						9-21-84			1 a.m.			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
male			white			06 30 1902			82			MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
Md.			U. S. A.						Dorchester			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cambridge			Cambridge House			executive			hardware			21613			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Md.		Dor.		Cambridge		YES <input checked="" type="checkbox"/>		602 Water St.							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Harry S. Keenan			Alena									Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
Yes			WW 2 217-10-8796			Frances J. Keenan			Item # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 x 24 hrs			
DOUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												}			
DOUE TO, OR AS A CONSEQUENCE OF (c) _____												}			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: OBS TIAS															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
—			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (we) attended the deceased from 2/20 1984 to 9/21 1984, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			22c. DATE SIGNED									
Hubert J. Frey			MD			9/21/84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
Hubert J. Frey MD			503 BYRN STREET												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN						
burial			9/23/84			Trinity Churchyard			Church Creek Dor. Md.						
24. FUNERAL DIRECTOR			NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
THOMAS FUNERAL HOME						CAMBRIDGE MD.									



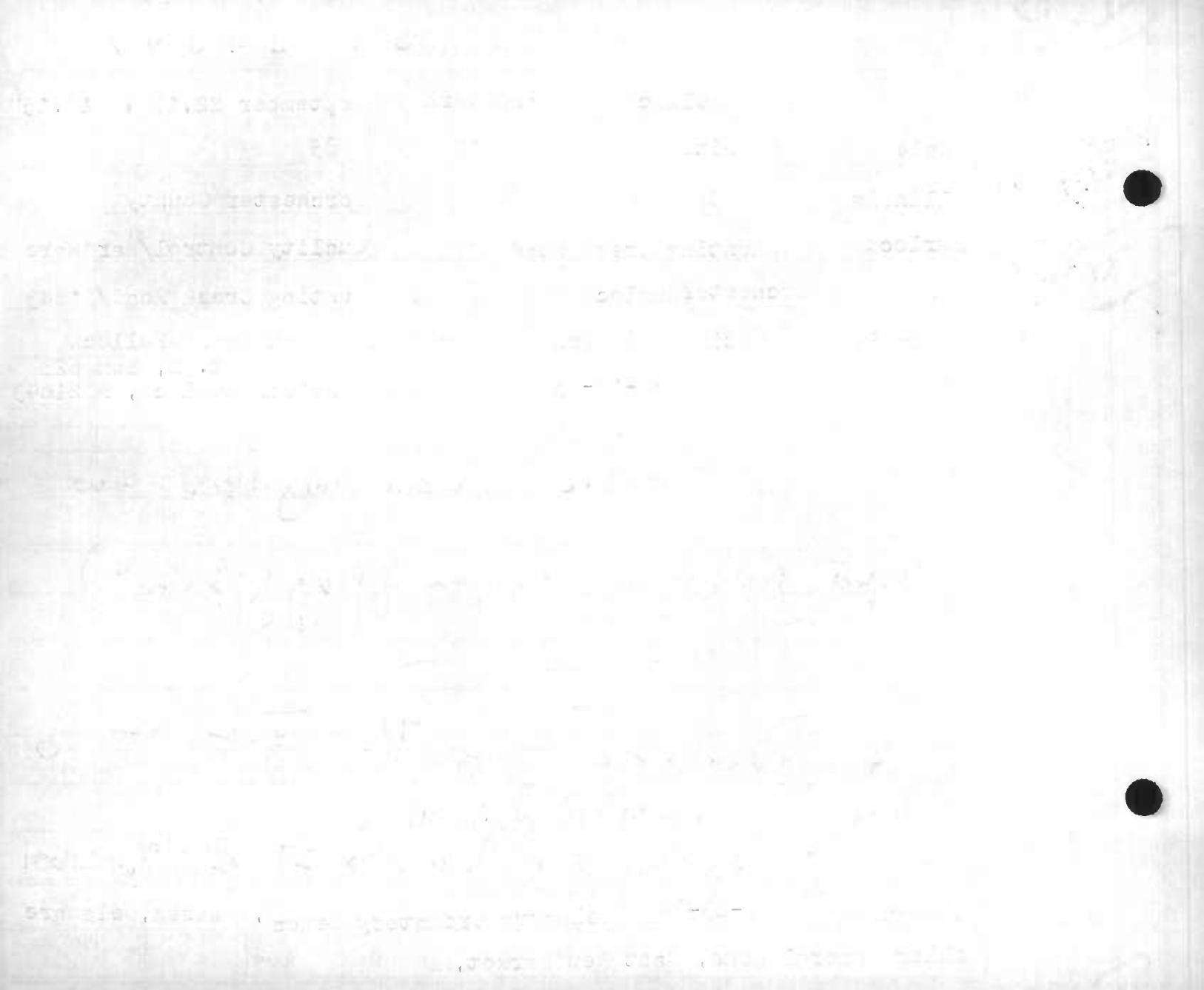
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely completed, it should be detached for use on the burial/tranport permit. Then please remove certain portions. Pages 1 and 2 should be filled within 72 hours of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma to the deceased, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												24891 REG. NO.			
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			3. FIRST MIDDLE LAST			4. DATE OF DEATH MONTH DAY YEAR			5. HOUR 10:15 A			
John Pollock Kniskern			September 22, 1984			2. SEX Male		3. RACE White		4. DATE OF BIRTH MONTH DAY YEAR		5. AGE (IN YEARS LAST BIRTHDAY) 85			
6. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County						
10. CITY OR TOWN OF DEATH Hurlock			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hunting Creek Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Control/Hardware			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE MD			13b. COUNTY Dorchester			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Hunting Creek Road/21643						
14. FATHER'S NAME FIRST Charles			MIDDLE Austin			LAST Kniskern			15. MOTHER'S MAIDEN NAME FIRST Pauline			MIDDLE Paterson		LAST Pollock	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI			16c. ADDRESS Rt. 2, Box 62B			17. INFORMANT Margarettta Kniskern Hurlock, MD 21643			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive lung disease</u>												YEARS.			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Suspect bronchogenic carcinoma of lung (not known to have</u>															
19a. DATE OF OPERATION ~			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) —									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)			21f. LOCATION STREET 79			CITY OR TOWN 922		COUNTY 19		STATE 84		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>2 weeks ago</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.												22c. DATE SIGNED 2013 SEP 22 1984			
22b. DEGREE Bachelor of Science in Nursing												22c. DATE SIGNED 2013 SEP 22 1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert T. DAWKINS JR. MD			22e. ADDRESS Route 3, Box 127			22f. STAFF ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-23-84			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware			COUNTY Sussex		STATE Delaware	
24. FUNERAL DIRECTOR Zeltier Funeral Home, East New Market, MD			25a. ADDRESS ADDRESS			25b. DATE REC'D. BY REGISTRAR UCI 5 1984			25c. REGISTRAR'S SIGNATURE June Davidson-Pendell						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
reached by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 when any injury, or other traumatic event, the medical examiner should be

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24898	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST OTIS	MIDDLE CARROLL	LAST LE COMPT JR.	20. DATE OF DEATH MONTH DAY YEAR	26. HOUR 7:05 PM					
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH AUG. 31 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER		MD.			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION DORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION REPAIRMAN		12b. KIND OF BUSINESS OR INDUSTRY C & P TEL. CO.					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Rt. Box 7, Cambridge		Md. 21613	
14. FATHER'S NAME OTIS		MIDDLE CARROLL	LAST LE COMPT	15. MOTHER'S MAIDEN NAME SR. BERTIE		16. ADDRESS ADKINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Betty Pritchett		18. ADDRESS same as 13 e		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE</b>										YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>GASTRO INTESTINAL HEMORRHAGE, SHOCK, ANEMIA</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <b>9/23 1984</b> , and that in <input type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) not view the body after death.											
22b. SIGNATURE <b>Michael A. Moskewicz MD</b>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael A. Moskewicz MD</b>		22e. ADDRESS <b>503 BYRD ST. CAMBRIDGE MD.</b>		22f. DATE SIGNED <b>9/23/84</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE <b>9/26/84</b>		23c. NAME OF CEMETERY OR CREMATORIAL Md. Vets. Cem. of E.S.		23d. LOCATION CITY OR TOWN <b>BEULAH, DORCHESTER, MD.</b>		COUNTY _____ STATE _____			
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME, ADDRESS CAMBRIDGE, MD. 21613		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <b>moskewicz</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Bind 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 24899		
1 - STATE REGISTRAR			2 - DATE OF DEATH: MONTH DAY YEAR 9/30/84									3 - HOUR: 3:15 A.M.		
1. DECEASED NAME (TYPE OR PRINT) Eugene N. LYONS			4. RACE: CAUCASIAN			5. DATE OF BIRTH: MONTH DAY YEAR 9 19 21			6. AGE (IN YEARS AS OF LAST BIRTHDAY) 03 yrs			7. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.		
3. SEX: M			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UPHOLSTERY			12b. KIND OF BUSINESS OR INDUSTRY SELF EMP.					
13a. STATE: Maryland			13b. COUNTY: Dorchester			13c. CITY OR TOWN: Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE: 1212 Race St. 21613		
14. FATHER'S NAME: FIRST OSCAR MIDDLE LYONS LAST			15. MOTHER'S MAIDEN NAME: FIRST NORA MIDDLE CAREY LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II			16b. SOCIAL SECURITY NO. 217 28 4421			17. INFORMANT: ELIZABETH LYONS ITEM #13			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Caroline Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Functioning Pacemaker in place														
19a. DATE OF OPERATION: N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			21b. TIME OF INJURY: HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION: STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (his hospital) attended the deceased from Sept 30, 1984, to Sept 30, 1984, that (I) (we) last saw the deceased alive on Sept 30, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE: Neal Reynolds MD			22c. DEGREE: ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED: 9/30/84								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) H. Neal Reynolds			22f. ADDRESS: 408 Byrd St Cambridge Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE: 10/2/84			23c. NAME OF CEMETERY OR CREMATORIUM: CAMBRIDGE CEM.			23d. LOCATION: CITY OR TOWN: CAMBRIDGE DOR. MD. COUNTY STATE					
24. FUNERAL DIRECTOR: NAME: THOMAS FUNERAL HOME ADDRESS: CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR: 10/6/84			25b. REGISTRAR'S SIGNATURE: Julie Davidson, RN, LPN								

25 May 1968 - 1000 hrs. 25 May 1968 - 1000 hrs.

Local time

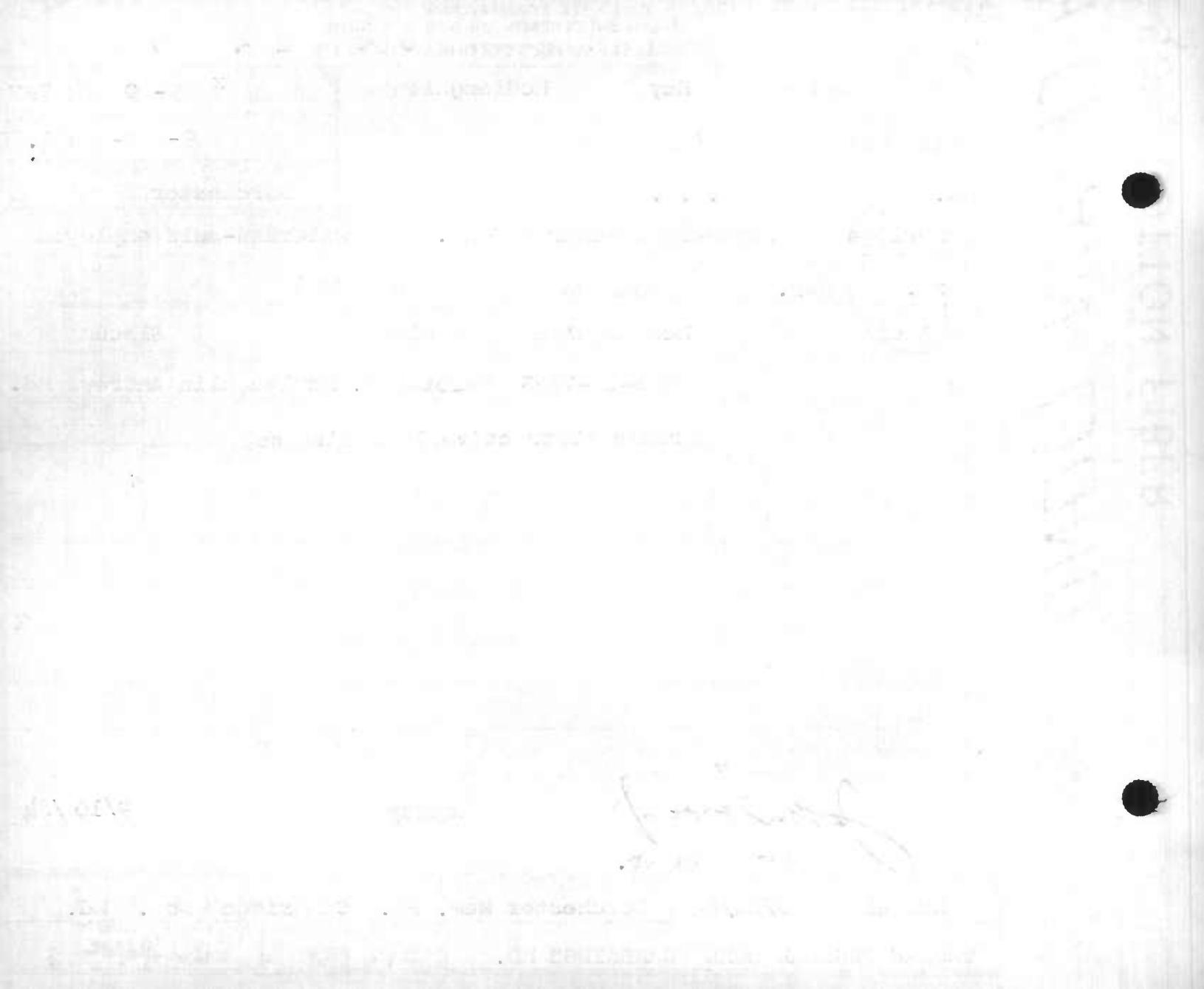
Local time

25 May 1968 - 1000 hrs. 25 May 1968 - 1000 hrs.

Local time

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 13e per phone 9/25/84 dad STATE OF MARYLAND FOR 1 - STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH					2 4 9 0 0		
										REG. NO.	9-9-84	19	YEAR	7PM			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR				
George		Guy		McGlaughlin				<input checked="" type="checkbox"/>		9	9	84	7PM				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 11 DAY 15 YEAR 1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YR. MONTHS		8. IF UNDER 24 HRS. DAYS		9. DATE PRONOUNCED DEAD		10. MONTH	DAY	YEAR	11. HOUR
												9- 9- 84		19	7PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester									
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman-self		12b. KIND OF BUSINESS OR INDUSTRY employed											
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Andrews		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rural		21613							
14. FATHER'S NAME Wilbur		15. MOTHER'S MAIDEN NAME McGlaughlin		16. SOCIAL SECURITY NO. 213-22-7353		17. INFORMANT Dorothy W. McGlaughlin		ADDRESS Andrews Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive lung disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr.		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/12/84		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk.		23d. LOCATION CITY OR TOWN Cambridge		COUNTY Dor.		STATE Md.							
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR SEP 14 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24901 REG. NO.	
1. FOR STATE REGISTRAR			2. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Sept. 7 1984		0630 <sub>M</sub>
Charlotte T. Merrick											
3. SEX female			4. RACE white		5. DATE OF BIRTH MONTH 06 DAY 22 YEAR 1942		6. AGE (IN YEARS LAST BIRTHDAY) 42			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			YRS.	
10. CITY OR TOWN OF DEATH E. New Market			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Main St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY MD.			
13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN E. New Market		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS N. Main St. 21631		
14. FATHER'S NAME FIRST Myron MIDDLE W. LAST Thomas			15. MOTHER'S MAIDEN NAME FIRST Ruth MIDDLE LAST Brinsfield								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-42-0004			17. INFORMANT Linford G. Merrick			ADDRESS P.O. Box 156 E. New Market		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINoma ENDOMETRIUM APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1982											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b),											
DUE TO, OR AS A CONSEQUENCE OF (c),											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11/1/82, 19, to 9/7/84, 19, that (I) (we) last saw the deceased alive on 7/17/84, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE CRW Bain			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/10/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CRW Bain			22e. ADDRESS Easton, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 9/9/84			23c. NAME OF CEMETERY OR CREMATORIAL E. New Market			23d. LOCATION CITY OR TOWN E. New Market		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR SEP 14 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall		

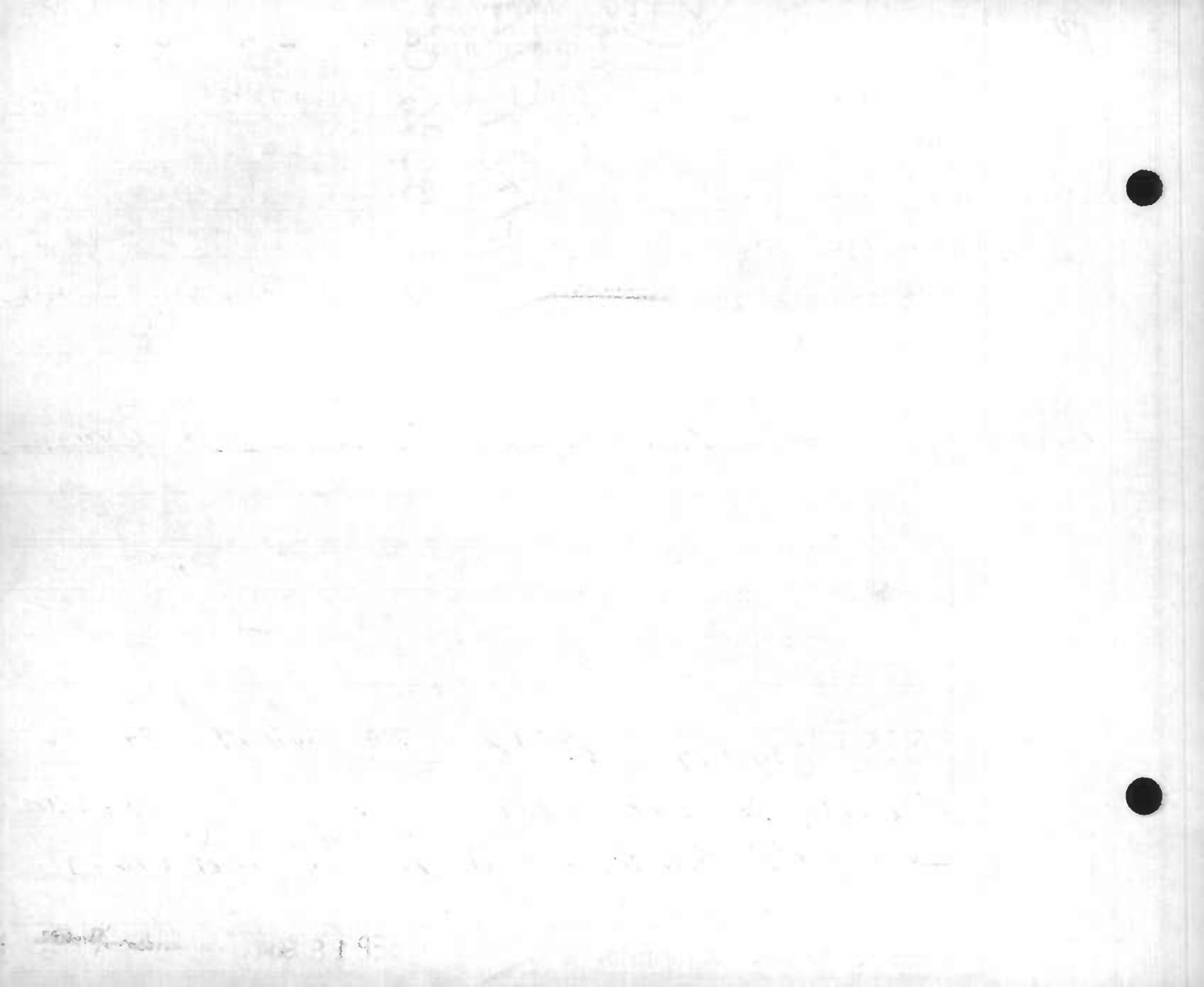


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 24902								
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 91 17 84									2b. HOUR 10 <sup>20</sup>								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Frank L. Mewshaw									62			MONTHS		DAYS						
3. SEX M			4. RACE Col			5. DATE OF BIRTH MONTH 06 DAY 17 YEAR 22			7. a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12a. USUAL OCCUPATION retired			12b. KIND OF BUSINESS OR INDUSTRY Store owner											
13a. STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 217 Hurlock			21643					
14. FATHER'S NAME FIRST MIDDLE LAST Frank L. Mewshaw Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Loretta Klug																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-364290			17. INFORMANT Marie B. Mewshaw, Same as 13														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelocytic leukemia 6 mos												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), DUE TO, OR AS A CONSEQUENCE OF																				
DUE TO, OR AS A CONSEQUENCE OF (b), (c), DUE TO, OR AS A CONSEQUENCE OF																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from May 84 to Sept 17 1984, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on May 17 1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.																				
22b. SIGNATURE Lewis M. Baradell MD DEGREE												22c. DATE SIGNED 17 SEP 84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Baradell			22e. ADDRESS 4 Arbor ST Cambridge MD 21617			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 20, 84			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie COUNTY AA STATE MD											
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD ADDRESS						25a. DATE REC'D. BY REGISTRAR SEP 18 1984			25b. REGISTRAR'S SIGNATURE John D. Anderson, Jr.											

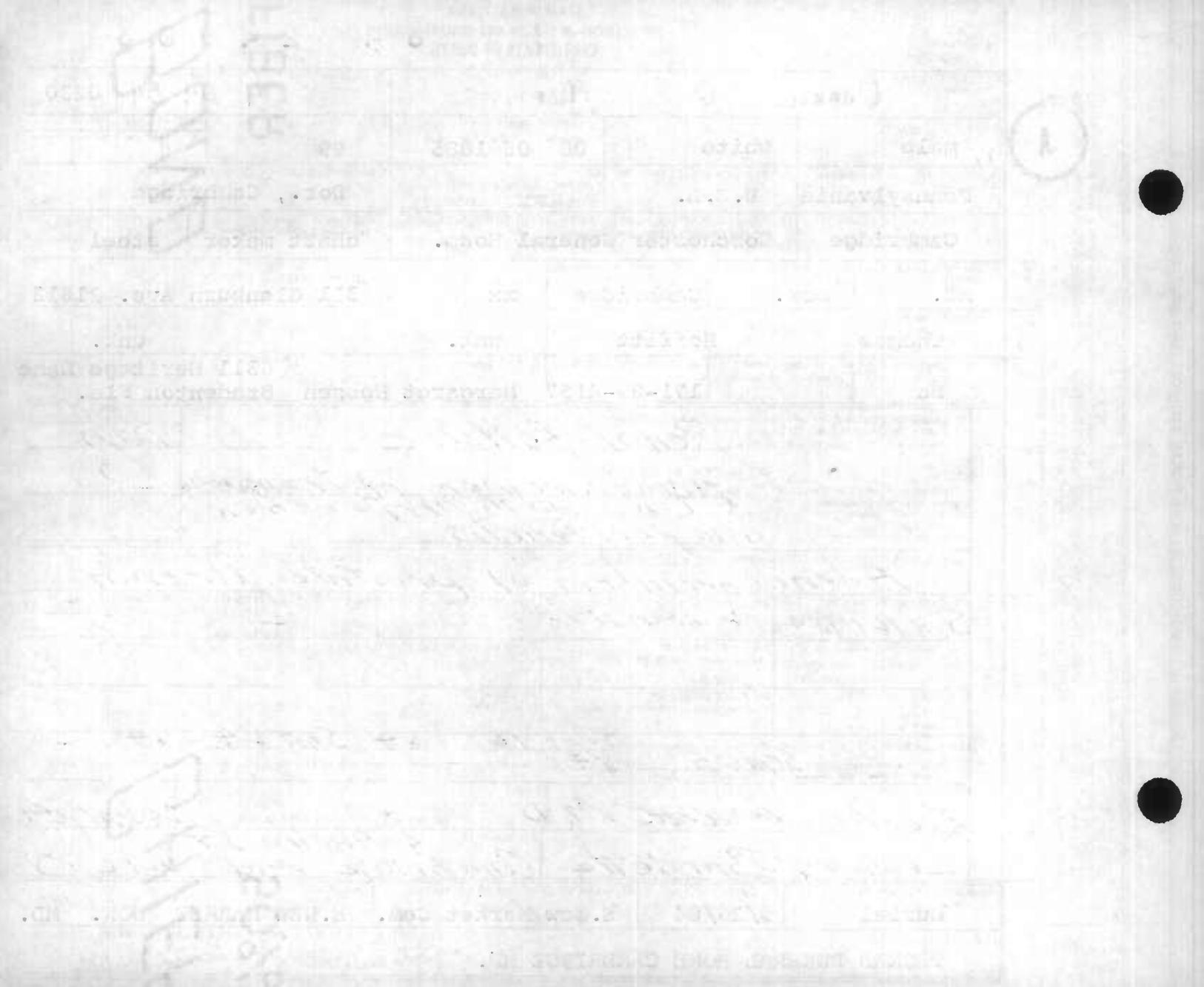


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												24903					
REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
CHARLES G. MOFFITT						9 24 84						0230 M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
male			white			MONTH 08 DAY 05 YEAR 1885			99			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Pennsylvania			U. S. A.						Dor., Cambridge			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Cambridge			Dorchester General Hosp.			chart maker			steel								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Md.			Dor.			Cambridge			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			311 Glenburn Ave. 21613					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
Thomas			Moffitt			unk.											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			171-09-4157			Margaret Nessen			6311 Heritage Lane			Bradenton Fla.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Renal failure												20 days					
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of prostate?																	
DUE TO, OR AS A CONSEQUENCE OF (c) Prostate with perforation and peritonitis																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
Sept 16 1984			Penitritis			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from Sept 16, 19 84 to Sept 24, 19 84, that (I) (we) last saw the deceased alive on Sept 24, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Lewis M Burdette MD												29 Sept 84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Lewis M Burdette			4 Aurora St Cambridge Md 21613			burial			9/26/84			E. New Market Cem.			E. NEW MARKET DOR. MD.		
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
THOMAS FUNERAL HOME			CAMBRIDGE MD.			SEP 27 1984			Julie Davidson-Pandore								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 2 4 9 0 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
KENNIE L. NICHOLS							<input checked="" type="checkbox"/>	9-19-84						
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Negro	Jan 21, 1894	90							9-19-84			19	7:30P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH	MD.				
Cokesbury, Md.		U.S.A.			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	DORCHESTER COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cambridge		Dorchester Co. General Hospital			Farmer			Farming						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21613				
Maryland		Dorchester		Seaford		Rt. 3, Box 257								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
John F. Nichols						Elizabeth Ann								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Delaware 19983						
Yes		WWI		221-05-6330		Jessie L. Payne, Rt. 1, Box 332, Seaford,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8902										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Smoke and soot inhalation and thermal burns DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 20:30 P.M. MONTH 9 YEAR 84 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found in burning car as a result of a housefire		20. AUTOPSY?								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) residence		21f. LOCATION Rt. 3 Box 257 Cokesbury Rd. Dorchester Co., Md.										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE		Margarita A. Korell, M.D.								TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		111 Penn Street								DATE SIGNED 9-20-84				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Sept. 22, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Cokesbury Cemetery		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME		ADDRESS		Federalsburg, Md.		ADDRESS		Federalsburg, Md.		ADDRESS		Federalsburg, Md.		
Frampton-Hawkins Funeral Home, 216 N. Main St.														
IN THE OFFICE OF THE REGISTRAR FOR REGISTRAR'S SIGNATURE Sept. 27, 1984														



Brooks, ~~date dictated~~ ~~date dictated~~

and, ~~dictated~~

~~dictated~~ ~~dictated~~

Brooks, ~~date dictated~~ ~~date dictated~~

Brooks

Brooks



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 24905									
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
3. SEX MALE			4. RACE CAU.			5. DATE OF BIRTH Sept. 15, 1891			6. AGE (IN YEARS LAST BIRTHDAY)			92		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER			YRS		MD.							
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House Nursing Fac.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman			12b. KIND OF BUSINESS OR INDUSTRY shellfish			13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 520 Glenburn Ave.	
14. FATHER'S NAME SAMUEL			15. MOTHER'S MAIDEN NAME JENNY			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT Helen Brown,			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosclerosis - Chronic renal Failure</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u>			DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												54 yrs		2 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>8/12/84</u> , 19 <u>84</u> , to <u>9/6/84</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7/3/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED									
22b. SIGNATURE <u>Lawrence Mayznow M.D.</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS <u>600 Race St.</u> <u>Cambridge, MD</u>															
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lawrence Mayznow, M.D.</u>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 9/8/84			23c. NAME OF CEMETERY Hosier Mem. Church			23d. LOCATION CITY OR TOWN Hooper's Isl., Dor. COUNTY STATE									
24. FUNERAL DIRECTOR NAME <u>Curran, 508 High St., Cambridge, Mu.</u>			25a. DATE REC'D. BY REGISTRAR SEP 11 1984			25b. REGISTRAR'S SIGNATURE															



1980  
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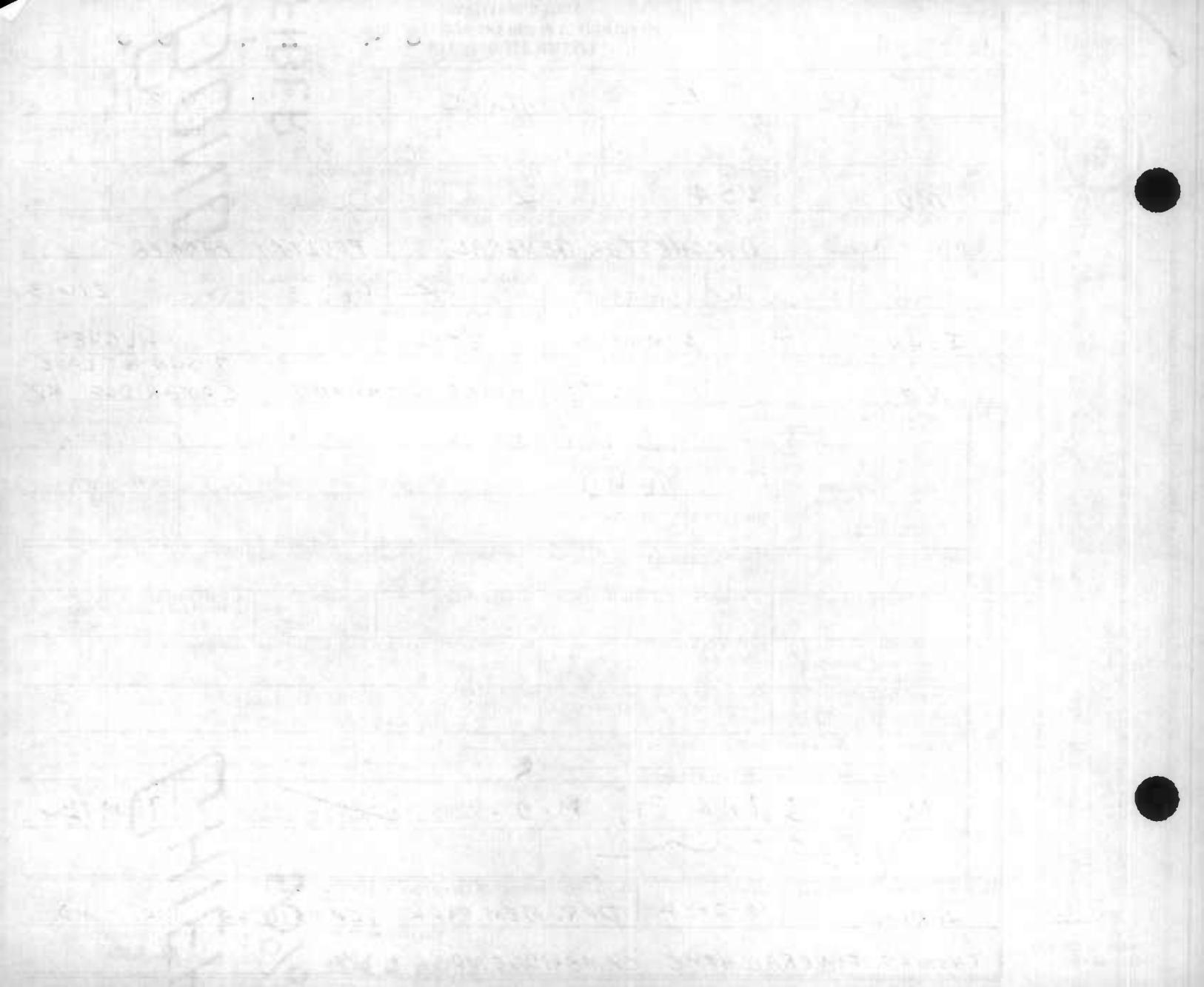
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24906						
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
CARL L. SIMMONS									9 29 84			M				
3. SEX Male			4. RACE Cauc.			5. DATE OF BIRTH MONTH DAY YEAR 10 12 00			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			MD.				
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POULTRY FARMER			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RFD 3 - 150 21613				
14. FATHER'S NAME FIRST MIDDLE LAST JOHN T. SIMMONS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETTA HUGHES			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-32-9782			17. INFORMANT ALICE GIORDANO			ADDRESS 7 SUNSET LANE CAMBRIDGE MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u>										DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>M. S. SHARIT, M.D.</u>										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>yes</u>										22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-2-84			23c. NAME OF CEMETERY OR CREMATORY DOR. MEM PARK			23d. LOCATION CITY OR TOWN CAMBRIDGE			23e. COUNTY DOR. MD.				
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR 5 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

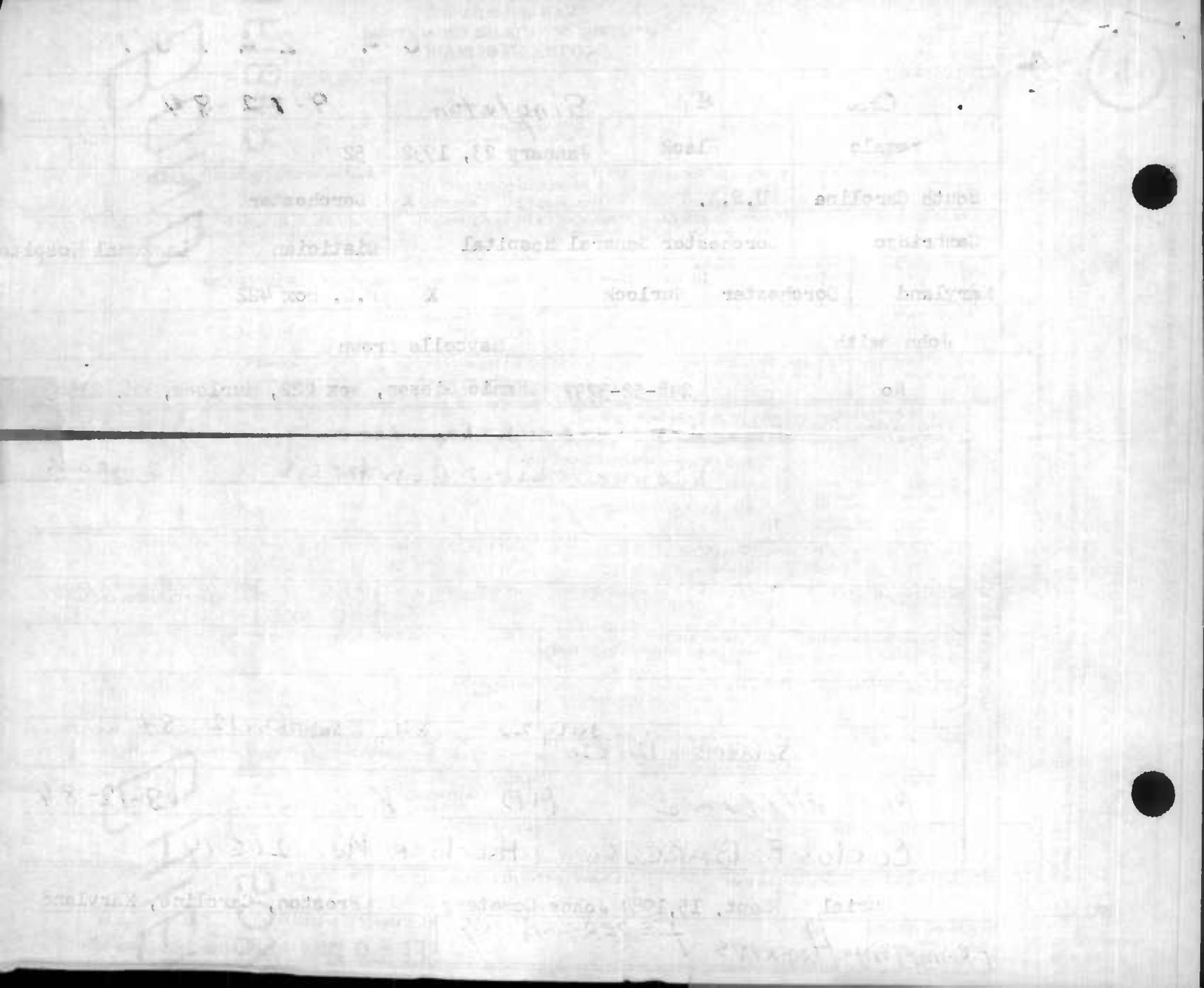


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24907 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Ora			E. Singletan			9-12-84						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR January 23, 1932			6. AGE (IN YEARS LAST BIRTHDAY) 52			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			M.		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietician			12b. KIND OF BUSINESS OR INDUSTRY Lankunai Hospital			MD.		
13. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE P.O. Box 422 21643		
14. FATHER'S NAME John Smith		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME Maybelle Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 248-52-3297		17. INFORMANT Mamie Gibson, Box 422, Hurlock, Md. 21643			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatorenal syndrome</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (b) <i>Jaunee's Liver Cirrhosis</i> 2 years DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) September 12 1984		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> , 1984, to <u>September 12</u> , 1984, that (I) (we) last saw the deceased alive on <u>September 12 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Carlito Barroso</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9-12-84					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Carlos F. Barroso		22g. ADDRESS Hurlock Md. 21614										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 15, 1984 Johns Cemetery		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN COUNTY STATE			23d. LOCATION Preston, Caroline, Maryland					
24. FUNERAL DIRECTOR NAME FRAMPTON-HAWKINS		24b. ADDRESS FEDERALSBURG		25a. DATE REC'D. BY REGISTRAR SEP 19 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall					



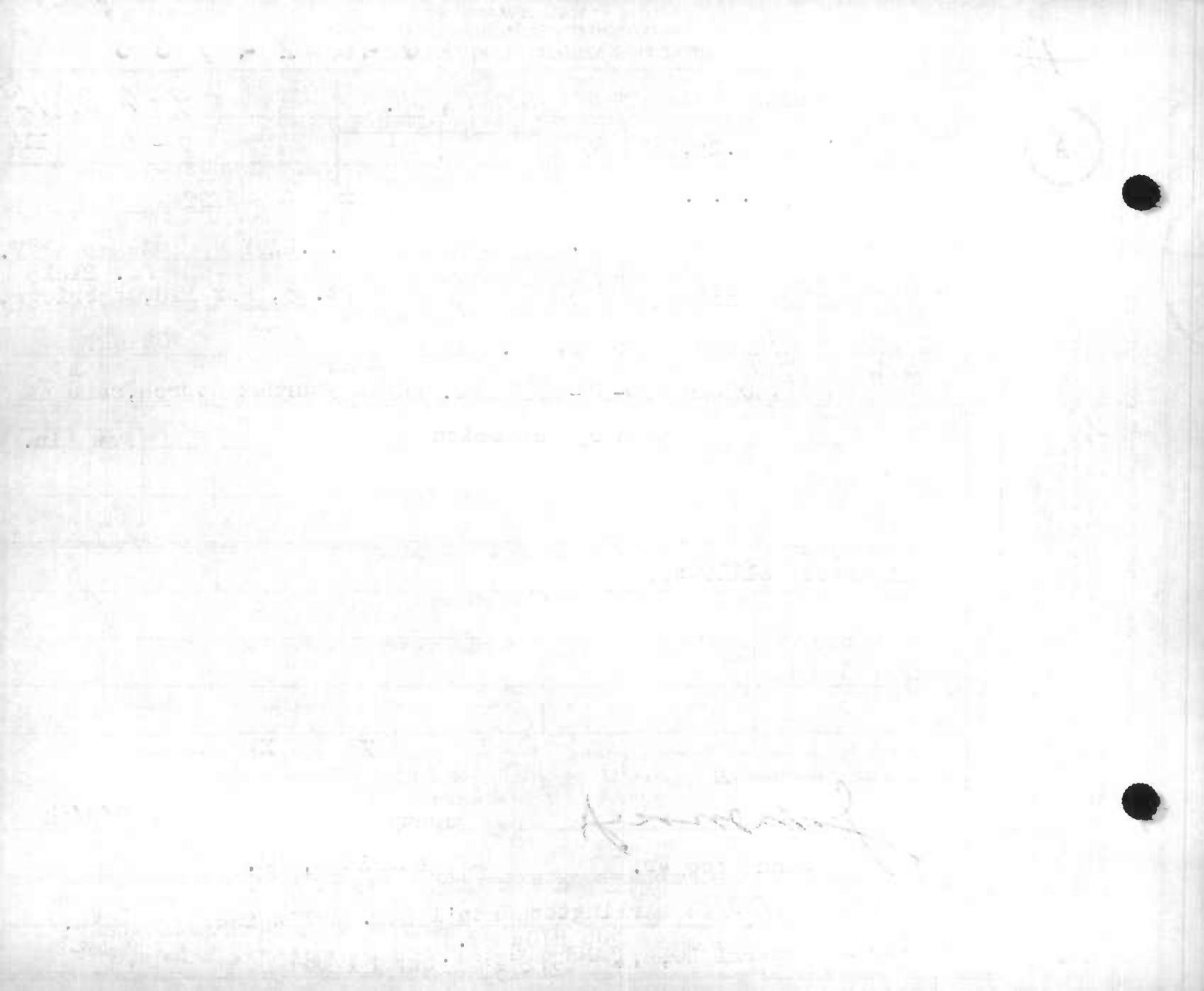
1- FOR  
STATE  
REGISTRAR

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PINE STREETS, BALTIMORE, MARYLAND, AND COPIES DICTATED TO BURIAL-TRANSIT CEREMONIES.

DIVISION OF VITAL RECORDS 281 W. PRESTON ST. BALTIMORE MD. 21201

1. DECEASED NAME (TYPE OR PRINT)			WALLACE GARRETT			STORCH, JR.			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR AM/PM								
3. SEX MALE			4. RACE CAU.			5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1926			6. AGE (IN YEARS LAST BIRTHDAY) 57 yrs.			7. IF UNDER 1 YR. MONTHS		8. IF UNDER 24 HRS. DAYS HOURS MIN.		9. DATE PRONOUNCED DEAD			MONTH DAY YEAR 9 - 6 1984			2d. HOUR 11A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER														
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. NAVY			12b. KIND OF BUSINESS OR INDUSTRY ARMED SERV.														
13a. STATE MARYLAND			13b. COUNTY DORCHESTER			13c. CITY OR TOWN ROSS NECK			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Box 118, Cambridge		Md. 21613										
14. FATHER'S NAME FIRST WALLACE			MIDDLE GARRETT			LAST STORCH, SR.			15. MOTHER'S MAIDEN NAME FIRST ADELE			MIDDLE FOURNET			LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II, KOREAN			16c. INFORMANT mother			16d. ADDRESS Mrs. Adele Fournet Storch, same as			16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Min.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Diabetes Mellitus</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			20. AUTOPSY?														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. LOCATION STREET CITY OR TOWN COUNTY STATE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>John Mace Jr.</u>																							
EXAMINER'S NAME (TYPE OR PRINT)			M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 9/6/84											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 9/10/84			23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cem.			23d. LOCATION CITY OR TOWN Arlington			COUNTY STATE Va.											
24. FUNERAL DIRECTOR NAME Curran Funeral Home, ADDRESS 308 HIGH ST. CAMBRIDGE, MD. 21613			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 11 1984 John Davidson-Rendell																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 5 should be filled with information concerning the deceased's death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												24909					
												REG. NO.					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR					
(TYPE OR PRINT)			9/15/84 9 15 84									7 1/2 PM M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		Month Day Year 6-13-35			49			MONTHS	YEARS	MONTHS	DAYS	HOURS	MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
Maryland		USA					Baltimore City or County of Death Dorchester			Cambridge							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD						13b. COUNTY Wic						13c. CITY OR TOWN Salisbury					
14. FATHER'S NAME FIRST LARRY						15. MOTHER'S MAIDEN NAME LAST KATHERINE						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)						16b. SOCIAL SECURITY NO. 217-30-8906						13e. STREET ADDRESS Kingswood Dr 41801					
16c. IF YES, GIVE WAR OR DATES						17. INFORMANT DONNA BREWER						18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest plus Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>due to aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Synpharyngitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Asthma</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>M. SADRI, MD</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 9/15/84								
22e. ADDRESS ESHC, Cambridge, Maryland 21613																	
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)			23b. DATE 9/18/1984			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park			23d. LOCATION CITY/TOWN Salisbury			COUNTY Wicomico			STATE Maryland		
24. FUNERAL DIRECTOR NAME Holloway Funeral Home			ADDRESS Salisbury, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 20 1984			25b. REGISTRAR'S SIGNATURE <u>J. L. B. B. P.</u>								
BP _____																	
DHMH - 16 50M 1/81 (VRA 15, 4)																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												24910 REG. NO.	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			September 6, 1984			4:45 PM	
Edgar C. VanDyke Jr.													
3 SEX male			4 RACE white			5 DATE OF BIRTH MONTH DAY YEAR 09 11 1910			6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester				
10 CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rural Route 2						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) boat builder			12b. KIND OF BUSINESS OR INDUSTRY & designer	
13a. STATE Md.			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1108 Locust St.	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Clair Van Dyke			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathrine Clark Hood						16. SOCIAL SECURITY NO. 578-26-7340			17. INFORMANT Henry A. Van Dyke	ADDRESS Rt. 2 Box 429 Cambridge Md
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC SG. CELL CA. TO LUNGS & BONE												MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (c) SG. CELL CA. OF RT. PIRIFORM SINUS												MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION 8-10-84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy, mass in neck						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from 8-4, 19 84, to 9-6, 19 84, that (I) (we) last saw the deceased alive 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE James F. McCarter, M.D.			DEGREE						22c. DATE SIGNED 9-6-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. McCARTER, M.D.			22e. ADDRESS 400 AURORA STREET CAMBRIDGE, MD. 21613										
23a. BURIAL, CREMATION, REMOVAL (SPECIES) burial			23b. DATE 9/8/84			23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Churchyard			23d. LOCATION CITY OR TOWN Cornersville		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.						25a. DATE REC'D. BY REGISTRAR SEP 13 1984		25b. REGISTRAR'S SIGNATURE John Davidson		



## TO HOSPITAL OR ATTENDING PHYSICIAN. The

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

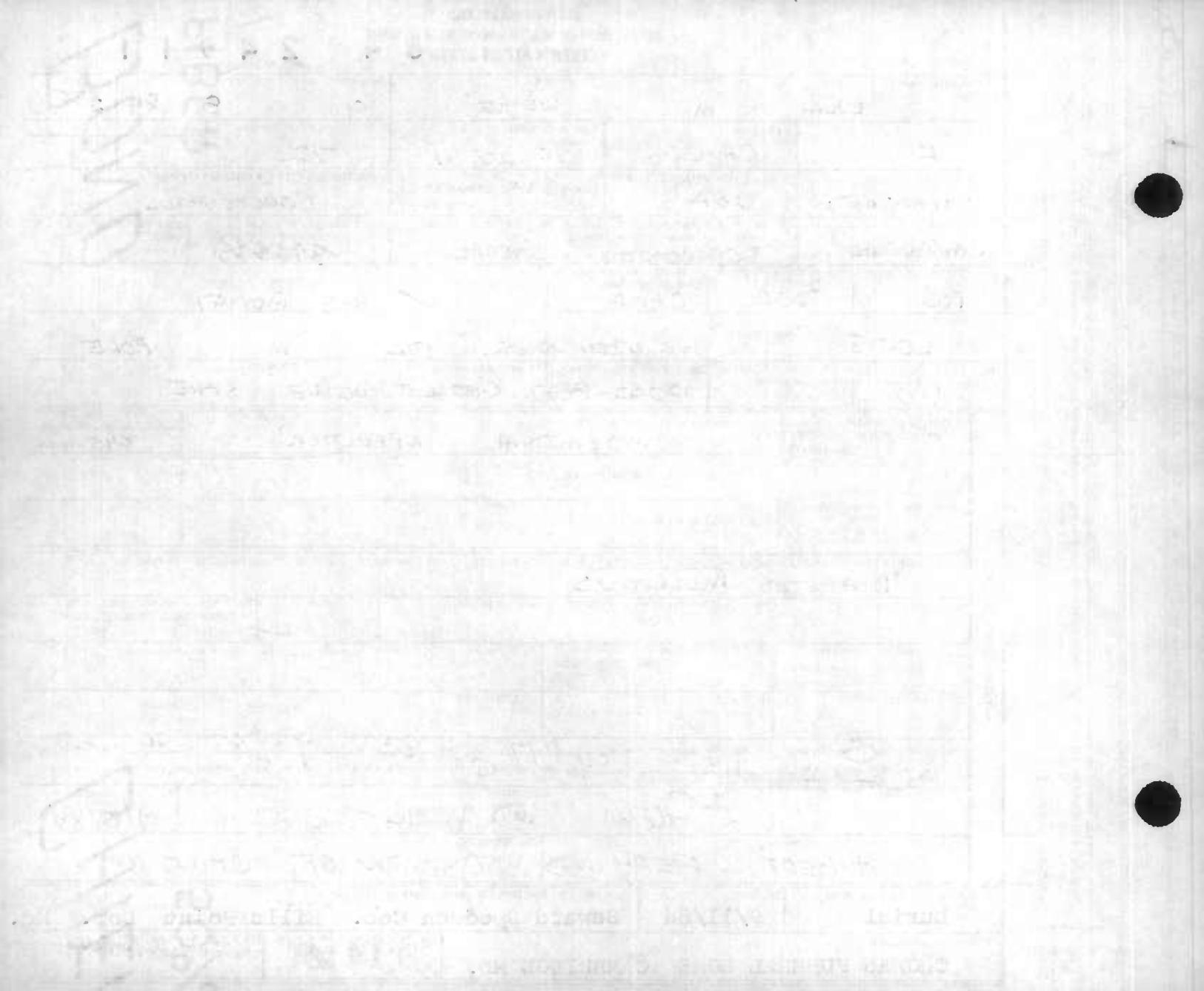
MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2491

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
LULA			M	WEIBE		91	8	84	235	PM	
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
F	CAUC	10 25 11	8	25	11	72	YRS.	MONTHS	MONTHS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND		USA				DORCHESTER			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CAMBRIDGE		DORCHESTER GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			13e. STREET ADDRESS / ZIP CODE			
MD	DORC	CAMB	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	R+3 Box 197			21613			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
LOUIS				HEINZENBERGER	IDA			M	POLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS			ADDRESS		
NO		220-22-8827		GEORGE WEIBE		SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>x45 min</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
DIABETES MELLITUS											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>9/18/84</u> to <u>9/18/84</u> , 19 <u>84</u> , and that in <u>my</u> ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>9/18/84</u> and that in <u>my</u> ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> ( <u>2</u> ) did not view the body after death.											
22b. SIGNATURE		<u>Hubert L. Fiery MD</u>		DEGREE	22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		MD	9/8/84						
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE				
burial		9/11/84	Seward Spedden Cen.		Hills Point	Dor.	Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE						
THOMAS FUNERAL HOME		CAMBRIDGE MD.		SEP 14 1984	John Dawson - Fiery						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

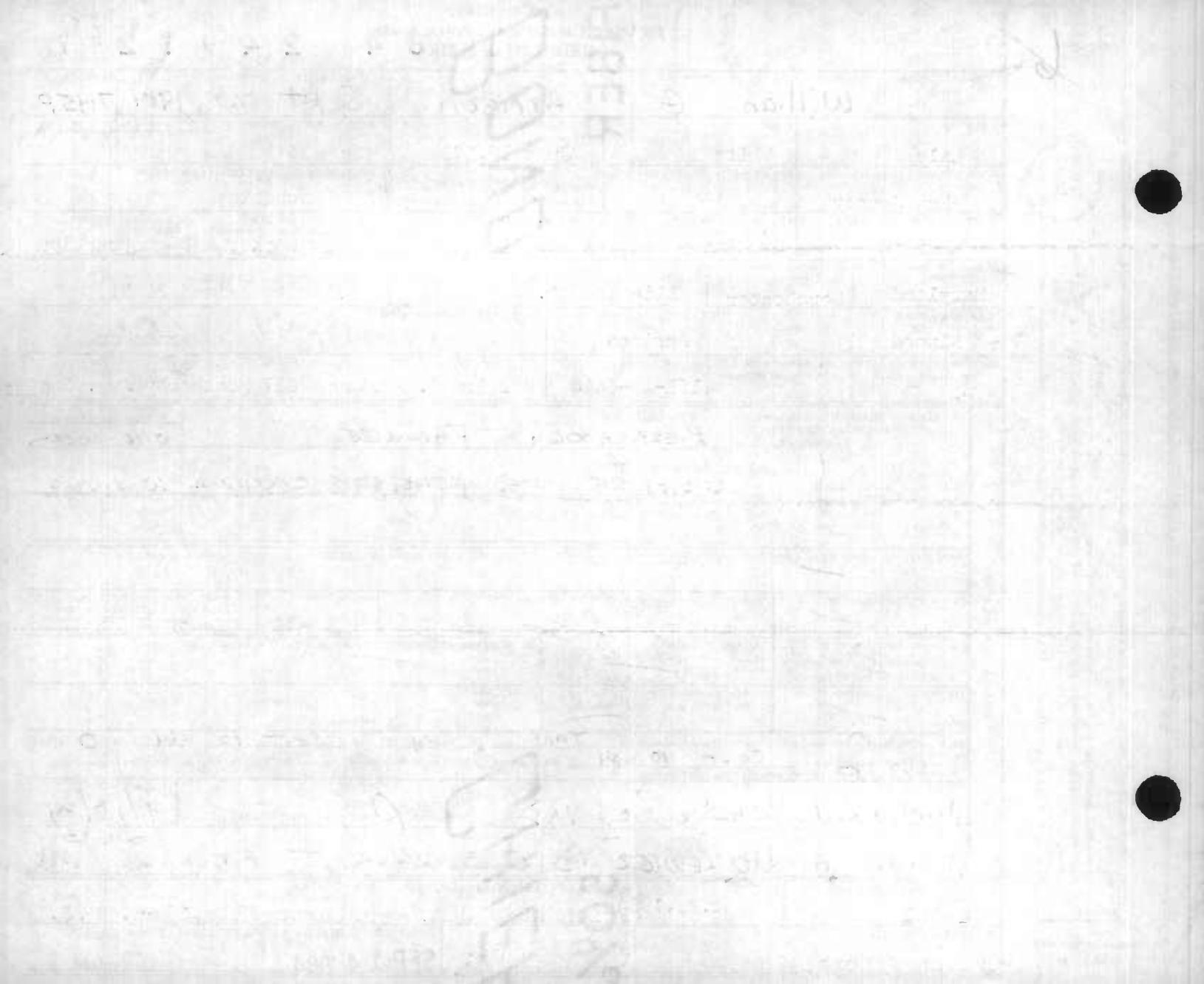
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24912  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
			William	G	Arrison	Sept 10, 1984				7145PM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)					
Male			White			June 16, 1928			56	YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
New Jersey			USA						Dorchester					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge			Dorchester General Hospital			12a. Ironworker			12b. Construction					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Dorchester			Elliotts Isl.						Elliotts Island 21823		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Elwood			Arrison			Mae						Bradshaw		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			151-20-6444			William E. Arrison			317 Weatherby Ave. Swedenboro			ONE WEEK		
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>UNDIFFERENTIATED METASTATIC CARCINOMA</u> 10 MONTHS														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that <input checked="" type="checkbox"/> (I) this hospital attended the deceased from <u>JAN</u> , 19 <u>84</u> , to <u>SEPT 10, 1984</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept 10, 1984</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (I) did not view the body after death.														
22b. SIGNATURE <u>Michael A. Moskewicz MD</u>			DEGREE			22c. DATE SIGNED 9/10/84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MICHAEL A. MOSKEWICZ MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <u>503 134th ST CAMBRIDGE MD</u>			22f. ADDRESS			21613		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 13, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Friendship Cem.			23d. LOCATION CITY OR TOWN Monroeville, Glos. N.J.			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Curran Funeral Home			ADDRESS 508 High St. Cambridge, Md.			25a. DATE REC'D. BY REGISTRAR SFP 14 1984			25b. REGISTRAR'S SIGNATURE <u>Carlson Pendell</u>					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Regarded by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24913

1. DECEASED-NAME (Type or print)	First <b>ALBERT</b>	Middle <b>REGINALD</b>	Last <b>ASKINS</b>	2a. DATE OF DEATH Month <b>SEPTEMBER</b>	2b. HOUR Year <b>1984</b>					
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH <b>OCT. 20, 1922</b>		6. AGE (In years last birthday) <b>61</b>	7. UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>DORCHESTER</b>	Md.						
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DORCHESTER GENERAL</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SERVICE MAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MD.</b>	13b. COUNTY <b>DOR.</b>	13c. CITY OR TOWN <b>CAMBRIDGE</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>431 HIGH STREET</b>	21613					
14. FATHER'S NAME First <b>CHAUNCEY</b>	Middle <b>ASKINS</b>	15. MOTHER'S MAIDEN NAME First <b>OLIVIA</b>	Middle <b>SAMPSON</b>	Last <b>SAME</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>	16b. SOCIAL SECURITY NO. <b>215-60-8900</b>	17. INFORMANT <b>Underlyne Askins</b>	Address <b>Same</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO (b) A CONSEQUENCE OF <b>Upper lobe Pneumonia AND</b>  DUE TO, OR AS A CONSEQUENCE OF (c) (b) <b>Emphysema</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>1) Parkinsonism 2) Shy Drager Syndrome</b>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPST? <b>YES</b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <b>9/17/84</b>	
22b. SIGNATURE <b>H. Neal Reynolds, M.D.</b>		ATTENDING HYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>405 Byrd St. Camb., Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>09-05-84</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ZION</b>	23d. LOCATION (City or Town) <b>FAST NEW MKT.</b>	(County) <b>DOE MD</b>	(State)					
24. FUNERAL DIRECTOR <b>Judice C. Delair, CAMBRIDGE, MD.</b>	ST. CROISSANT F. HOME	25a. REC'D BY REGISTRAR DATE <b>SEP 7 1984</b>	25b. REGISTRAR'S SIGNATURE <b>J. Neal Reynolds</b>							

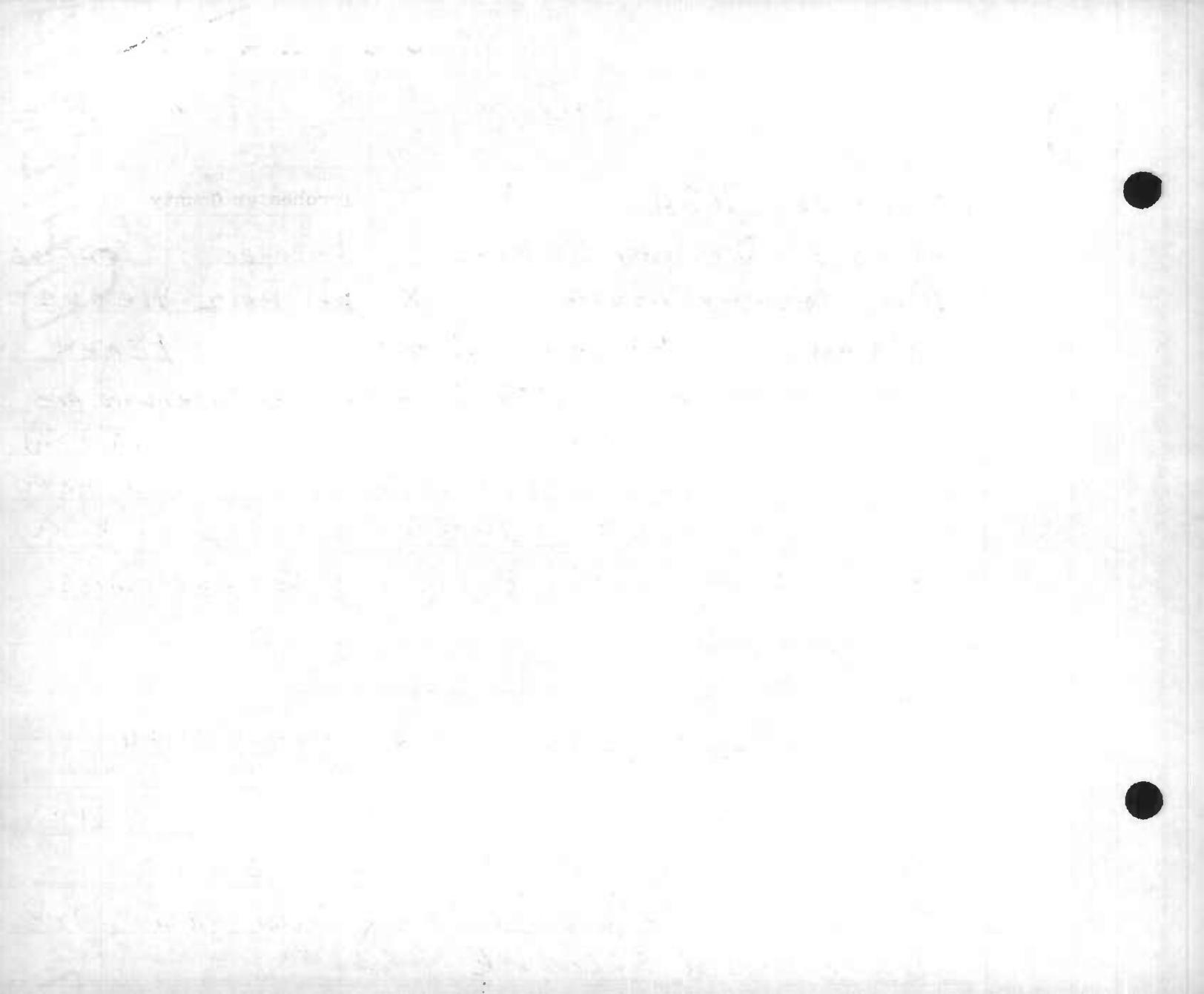


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please initial here if you are reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												24914	
												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			<i>Bettie M. Baltimore</i>						<i>09-21-84</i>			<i>7:20 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
<i>Female</i>			<i>Negro</i>			<i>01 06 21</i>			<i>63</i>			MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
<i>No. CAROLINA</i>			<i>U.S.A.</i>						<i>Dorchester County</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>CAMBRIDGE</i>			<i>Dorchester GENERAL</i>			<i>LABORER</i>			<i>SEAFOOD</i>				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
<i>MD</i>			<i>Dorchester</i>			<i>Vienna</i>						<i>21807 31 BX12 Vienna</i>	
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT	
<i>William</i>			<i>HOLDEN</i>			<i>MARY</i>			<i>218-22-5991</i>			ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO.			16c. ADDRESS			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
												<i>15 days</i>	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a)													
<i>Uremia</i>													
Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause (1b)												DUE TO, OR AS A CONSEQUENCE OF <i>Chronic renal failure</i>	
												1 year	
DUE TO, OR AS A CONSEQUENCE OF <i>Diabetic glomerulonephritis</i>												1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic brain syndrome due to arteriosclerosis</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>January 6, 1980</i> to <i>September 21, 1984</i> , that (I) (we) last saw the deceased alive on <i>September 21, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Carlos F. Barroso</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9.21.84</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS <i>MD Harlock Md 21643</i>			22g. ADDRESS			22h. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>9-24-84</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Greenwood Memorial</i>			23d. LOCATION CITY OR TOWN <i>Salisbury Md</i>			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <i>West Funeral Sales, Inc.</i>			ADDRESS			24e. DATE REC'D. BY REGISTRAR <i>SEP 27 1984</i>			24f. REGISTRAR'S SIGNATURE <i>Gene Dawson</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, IN BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RECAVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 4915 REG. NO.													
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
		William Albert Boevers						<input type="checkbox"/> MONTH DAY YEAR			9-30-84 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	
Male		White		4 24 64		20 yrs.						Sept. 30 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Germany		USA										Dorchester County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Dorchester General			Laborer/seafood			Packing					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
MD		Dorchester		Secretary		YES <input checked="" type="checkbox"/>		106 South Street/21664					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
William		G.		Boevers		Tuetje				Wellhoener			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS							
No		217-92-5905		William Boevers		106 South Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Suicide by hanging													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
9PM 9-30-1984				Hanged himself on telephone pole.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
At Work		Street		Moose Lodge Rd. Nr Cambridge, Dor. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		John Mace Jr. M.D.		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		DATE SIGNED							
EXAMINER'S NAME (TYPE OR PRINT)						10/3/84							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		10-3-84		East New Market Cem.		East New Market, Dorch., Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Zeller Funeral Home		East New Market, Md.		Oct 8 1984		John Mace Jr. M.D.							
DHMH - 17 (VR A15 ME (5))													
15M 7/77													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												24916		
REG. NO.											2b HOUR			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			CYRIL E CHILDE						9 13 84			11 05 PM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
M			White			7 19 87			97			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
NEBRASKA			U.S.						DARKESTON CO.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CAMBRIDGE			FORESTIER GENERAL HOSPITAL						TRANSPORTATION CONSULTANT					
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD			DARKESTON			CAMBRIDGE			RT. 44 BOX 277 21613					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
EDWARD P CHILDE			LUCY MITCHELL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			578-38-8767			WIFE - FRANCES			SAME			TERMINALLY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												(AS STATED)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any												MASSIVE ANTERIOR WALL MYOCARDIAL INFARCTION 21 DAYS W/VENTRICULAR ANEURYSM		
(b)														
(c)												ARTERIOSCLEROTIC CORONARY ARTERY DISEASE 10+ YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from 9-13 1984, to 9-13 1984, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did) view the body after death.												22b. DATE SIGNED 9-14-84		
22c. SIGNATURE Donald R. McWilliams, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald R. McWilliams, M.D.			22e. ADDRESS 308 GAY ST. CAMBRIDGE, MD. 21613											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 9/14/84			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN COUNTY STATE			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS Balto., Md.			25a. DATE REC'D. BY REGISTRAR SEP 18 1984			25b. REGISTRAR'S SIGNATURE John Anderson - McWilliams					



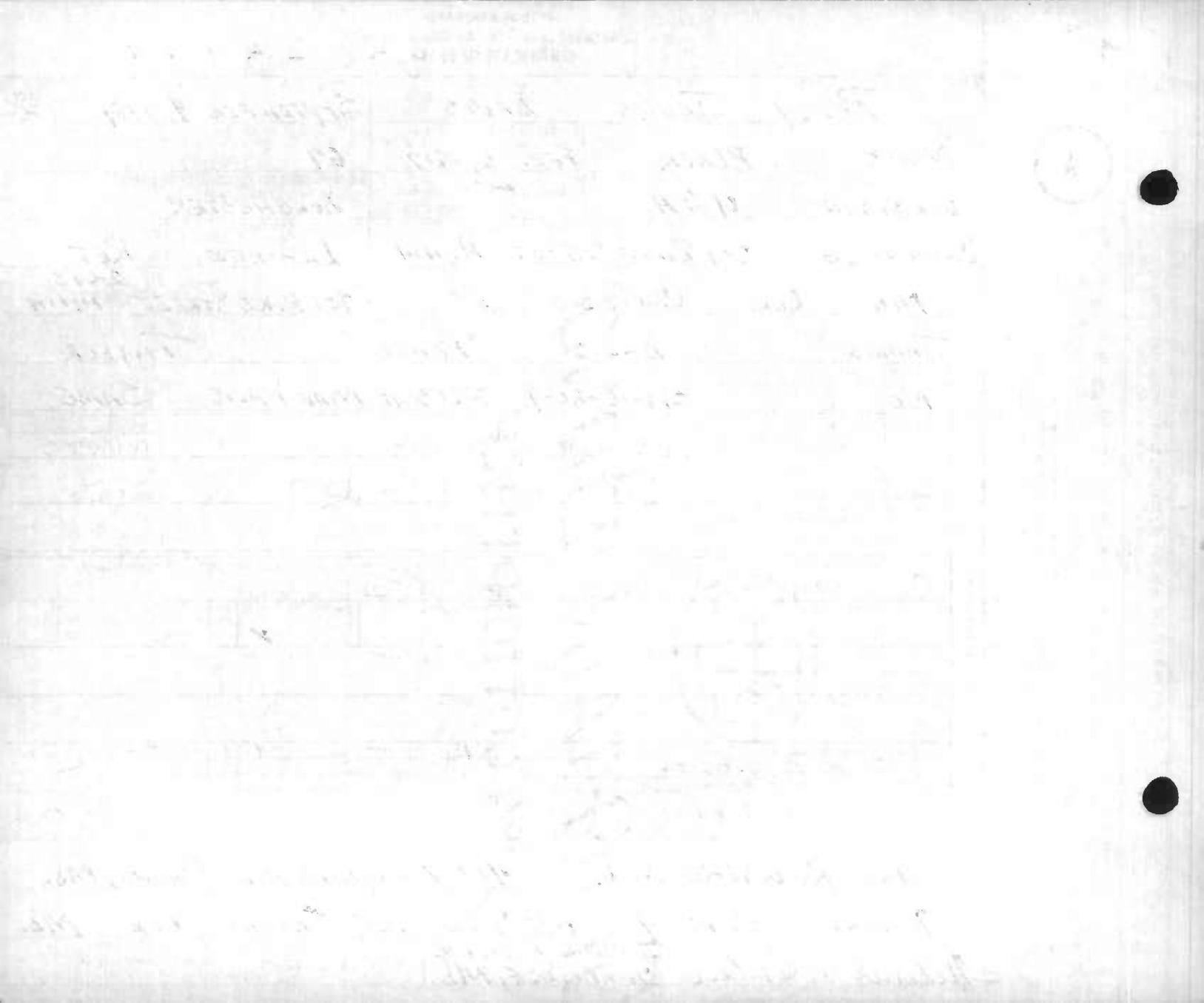
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24917  
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or if longer, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
<i>PERCY JAMES DAVIS</i>						SEPTEMBER	9, 1984			7:30 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
MALE		BLACK		MONT DAY YEAR FEB. 6, 1917		67									
8. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH					
VIRGINIA		USA				DORCHESTER				CAMBRIDGE					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)															
13a. STATE Md.			13b. COUNTY DOR.			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 701 RACE STREET A. 414			
14. FATHER'S NAME FIRST JAMES			MIDDLE			LAST DAVIS			15. MOTHER'S MAIDEN NAME PEARL			12a. USUAL OCCUPATION LABORER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT FLOSSIE MAE DAVIS			12b. KIND OF BUSINESS OR INDUSTRY RET.			18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c). Respiratory Failure			
															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Heart Disease, Angina.												2 yrs.			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1979</u> 19- to <u>9.9</u> 1984, that (I) (we) last saw the deceased alive on <u>6-05-84</u> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Ann R. Wilke, M.D.</i>			22c. DEGREE <i>MD</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ann R. Wilke, M.D.</i>			22e. ADDRESS <i>400 Maryland Ave Camb., Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>09-15-84</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>MT. PLEASANT</i>			23d. LOCATION CHERTWELL COUNTY STATE						
24. FUNERAL DIRECTOR NAME <i>Frederick C. St. Clair F. Home</i>									25a. DATE REC'D. BY REGISTRAR <i>SET 11 1984</i>			25b. REGISTRAR'S SIGNATURE <i>G. Kendall</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 12, AND SEND THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24918					
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9/3 1984									2b. HOUR AM					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept. 3, 1984			2d. HOUR AM		
Essie Mae Ennals												BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.					
3. SEX		4 RACE	5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept. 3, 1984			10. HOUR AM	
Female		Negro	Dec. 2, 1936			48 yrs.			MONTHS DAYS		HOURS MIN.						
11a. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge, Md.		Dorchester General Hospital										Laborer			21613		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			618 Greenwood Ave/					
Md.		Dor.	Cambridge														
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME						
Grant		Thomas						Ennals			Christine			Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										17. INFORMANT			ADDRESS		
No		220-32-7551										Betty Ennals			Cambridge, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Cardiac Arrest												Instant					
DUE TO, OR AS A CONSEQUENCE OF												?					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) Congestive Heart Disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
													YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
			HOUR A.M. MONTH DAY YEAR														
P.M.			19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			STREET			CITY OR TOWN					
												COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>John Mace Jr.</i>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.												DATE SIGNED 9/3/84					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION								
Burial			9/8/84			Waugh Cemetery			CITY OR TOWN			COUNTY Dor. STATE Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Stewart Funerals			Cambridge, Md.			SEP 6 1984						<i>Lidia Davidson-Rendell</i>					
DHMH - 17 (VR A15 ME (5))																	
20M 4/82																	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 4 9 1 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN AS OF DEATH ESTIMATED			2b. MONTH DAY YEAR	2b. HOUR PM			
Frank			Charles			Haring						9-29 19 84							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. MONTH DAY YEAR			2d. HOUR 1:30 PM	
male		white		08 26 1917		67						Sept. 29, 19 84							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			Dorchester			MD.				
Md.			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Cambridge			505 Gay St.			repairman-self emp.													
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21613						
Md.			Dor.		Cambridge		505 Gay St.												
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			LAST			Toffling						
Frank			Chase		Haring		Norma						7876 Belhaven Bea						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT Louise Polaski Pasadena Md			ADDRESS										
Yes			WW 2																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?				
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																			
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
												<input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that I took charge of the remains described above, held an															Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>				
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>John Mace Jr.</i>						TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 10/1/84							
EXAMINER'S NAME (TYPE OR PRINT)			John Mace Jr. M.D.			ADDRESS Cambridge, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 10/1/84			23c. NAME OF CEMETERY OR CREMATORIAL DELMARVA CREMATORY			23d. LOCATION CITY OR TOWN CAPE HENlopen			COUNTY DELAWARE							
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR 001 5 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Rendell</i>										
BP																			
DHMH - 17 (VR A15 ME (5)) 15M 2/80																			

